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ABSTRACT

While much of the development of consultation programs in mental health centers has been independent of the traditional treatment program, this document describes a consultation program which is closely integrated with an agency's treatment program. The emphasis is on system change and the development of prevention programming. The system-crisis model, as it is called, identifies treatment cases as having five perspectives: biological, intro-psychic, individual, family and community. This paper focuses on the community level intervention model and its four systems: community agencies, governing entities, formal groups and informal groups. The goal of mental health consultation is seen as increasing those behaviors in community systems which enhance the mental health of clients and decrease behaviors which are harmful to them. Included are assessment processes, intervention design, and implications and evaluation of the model. While geographically specific, the model could be adapted for other communities. (Author/BMW)

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A SYSTEMS-CRISIS MODEL OF MENTAL HEALTH CONSULTATION

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In recent years much of the development of consultation programs in mental health centers has been independent of the traditional treatment program. The present paper describes a consultation program which is closely integrated with an agency's treatment program. The program puts the emphasis on system change and development of prevention programming rather than simply enhancing the treatment services.

In several papers, the authors described in detail the systems-crisis model (Halpern, Gant, Canale and Bellamy, 1979), (Halpern, Gant and Canale, 1978). This model identifies treatment cases as having five perspectives or levels: biological, intra-psychic, individual, family and community. The development of this concept allows for the understanding of treatment cases from each level and allows intervention at all or any one level. The present paper will focus on the application of this model of intervention at the community level.

The Theoretical Model: The Eco-system and the systems-crisis model

The authors view the behaviors, which are of concern to the mental health professional, as occurring within a total "social eco-system". This represents the universe of entities that must be considered in understanding mental health and mental illness. A general systems approach

(Bertalanffy, 1968) is utilized to develop the model of the social eco-system and to explain the process of change in community systems.

One system's concept is that of levels of integration which is central to the development of this model. This concept, which has been of major value to biologists, was utilized by Adolph Meyer (Lief, 1948) in his development of the psychobiological approach to treatment of emotional disturbance. Basic to this is the notion that the world can be conceived of from a range of perspectives, each equally valid in the sense of being accurate, but differing in the operations and concepts used to describe phenomena. These perspectives are differentiated in terms of a series of levels at which explanation of the whole cannot be understood simply by an analysis into parts, but must be understood through knowledge of the organization of parts. Levels are also defined in terms of the emergence of new uniting entities. Thus, at each level the elementary unit is something which, when viewed from the perspective of any lower level, can be analyzed into parts.

The phenomena which are of concern to the mental health professional cover a broad range and do not fit neatly into any single field of study. Factors of concern to biologists, psychologists, sociologists, and anthropologists are all of concern to the mental health field. By organizing these factors in terms of phenomena occurring at various "levels of integration", the wide diversity of data which is important in dealing with emotional disturbance can be handled independently. Mental health issues then may best be understood in terms of multi-level analysis of the phenomena involved.

The authors postulate five (5) levels of analysis, each representing qualitative changes created by increasing complexity in terms of social

interaction. At the first level are the biological systems which affect mental health and illness. Examples of biological systems would be the endocrine system and the central nervous system. The biological level is an important base which has effect on, and implications for, all higher levels.

The next level of analysis is the intra-psychic level. It does not deal with social interaction directly. It is related to social interaction only in that interaction phenomena are used to describe the development of intra-psychic phenomena and that intra-psychic phenomena may affect social interactions. Units of analysis at this level include such entities as thought, feelings, values and beliefs.

The next level labeled the individual level is one in which interaction is viewed as occurring directly between the individual and his environment, both psychological and social. It is also one in which the individual behavior changes in response to the environment. Behaviors represent the elementary unit at this level.

The fourth level of analysis, the primary group level, focuses on those small enduring groups such as the family and the marital dyad which play major roles in socialization of the individual. The unit is no longer the individual but the group itself and the focus is not individual behavior, but rather group behavior.

The final level of analysis concerns itself with those groups, organizations and institutions in the community which affect individual and family mental health. This level is identified as the community level. The authors have identified four types of systems at the community level to account for existing community theories relative to mental health. These include:

1) community agencies; 2) governing entities; 3) formal groups; and, 4) informal groups which include broad categorizations of individuals such as, ethnicity, social class, and neighborhoods. Fig. 1 depicts the levels, systems, and elementary units of each level within the social eco-system.

The focus of the present paper is on those systems at the community level. As viewed by the present authors, the goal of mental health consultation is to increase those behaviors in community systems which enhance the mental health of their clients and to decrease behaviors of community systems which are harmful to the mental health of their clients. In order to accomplish these goals, a model has been developed which provides a rationale for community interventions, based on a diagnostic assessment of the problems and an evaluation of outcome of past intervention.

The rationale rests on the assumption that all community systems may be viewed as open systems. A number of characteristics of the open system are of special significance in relation to the present theory. One of the distinguishing characteristics of these systems is the ability to grow and differentiate. It is this ability which allows for adaptation to an ever-changing environment. Even in the face of such changes, these systems maintain a basic continuity in form and maintain a steady state of equilibrium with regard to certain key variables. This homeostatic aspect of the system obviously sets some limits to the ability of the system to change in response to its environment. Thus, some limits are set on the systems' ability to adapt. The equilibrating process described above occurs in systems at all levels. Thus, limits are set on adaptation for individuals, primary groups, and community systems by those parts of the system at each level which maintain homeostasis.

FIG. 1

THE SOCIAL ECO-SYSTEM

Level	Systems	Elementary Units
Biological	Endocrine Nervous etc.	Cell
Intra- Psychic	Cognitive Emotional	Thoughts and feelings
Individual	Behavioral System	Stimulus Behavioral response
Primary Group	Marital Family	Interpersonal communication
Community	Agency Government agencies Formal Groups Informal Groups	Behavioral Role

Within this model, emotional disturbance may be conceived of as failure of any of the systems within the total social eco-system to produce adaptive responses to the existing environment. Such a failure may occur either because the system has not previously faced a similar environmental situation, and has not been able to grow or develop in the manner necessary to cope with that situation or because the production of an adaptive response to the situation is precluded by the limits placed on change by the system's homeostatic mechanisms. When the homeostatic system processes prevent adaptation to a situation and the system repeatedly produces maladaptive responses, change can occur only if the basic structure of the system is reorganized. It is hypothesized that this is a type of change which can occur only after the system has gone through a period of disorganization. This disorganization-adaptation process has a prototype in the existing mental health literature. Crisis theory (Caplan, 1964) portrays this type of process. Caplan has given the following description of crisis:

> "Typically an individual handles problems by bringing into play a variety of problem-solving mechanisms, one of which solves the problem. Before the solution occurs the person is in a state of tension, which does not become excessive simply because the state is short-lived and the person is accustomed to such periods of tension. In crisis, however, the tension is much greater, first because the problem is more significant and, second, because the individual's usual way of dealing with problems offer no solution. The uncomfortable state in which the individual finds himself is of much longer duration than it is in his usual problem-solving activities and he develops a feeling of helplessness and ineffectiveness. These feelings are associated with some disorganization of function which may consist either of attempts at discharging inner tension or trial-and-error attempts to solve the problem. Through this behavior the individual may either develop new methods of dealing with his problem or fail and simply avoid a solution. The new methods of problem-solving developed during crisis are added to his repertoire of behaviors and, if effective, will be of aid in the future. Inability to deal with the problem or a poor solution will inhibit future ability to cope with problems." (p.162, 1964)

While this description is phrased in terms of individual behaviors, the systems disorganization model described above is clearly a more general statement of the same theory.

Using the model, maladaptive behavior in community systems is viewed as a function of 1) lack of experience (i.e., the natural growth process of the system has not proceeded far enough so that an adaptive means of coping with the existing environment might be developed), or 2) the limitation on change exerted by the homeostatic mechanism of a system. Modification of maladaptive patterns may be brought about by the 1) enhancement of natural growth, or by 2) the stimulation and adaptive resolution of crisis. The methods used to identify maladaptive community system behavior and to implement the two types of intervention described above will be detailed in the remainder of this paper.

The Assessment Process

The first step in applying the systems-crisis model to consultation has been the development of a language for describing and classifying system dysfunction. Development of the classification system was based on a number of years' experience with case and system consultation to a wide range of community systems and feedback from our clinical caseload.

Three general categories of dysfunctional community system behavior have been identified: 1) behaviors that devalue the client; 2) behaviors that unduly stress the client; and 3) behaviors which confuse the client. Fig. 2 lists specific dysfunctional behaviors. While it is probably not an exhaustive listing, it does cover all dysfunctional behaviors identified by a dozen consultants, each with at least two to three years of experience working with community systems. To date, this diagnostic categorization has

Fig. 2

I. Dysfunctional Behavior

A. Behaviors which devalue the client

1. infantilization of clients
2. lack of respect for client's dignity
3. devaluing of client feelings

B. Behaviors which unduly stress clients

1. behavior producing unnecessary fear in clients
2. behaviors producing unnecessary anxiety in clients
3. behaviors producing unnecessary hostility in clients
4. behaviors producing unnecessary guilt in clients
5. double bind communication to clients
6. inability or unwillingness to deal with emotional aspects of client problems

C. Behaviors which unduly confuse and frustrate clients

1. consultee overreaction to bizarre behavior
2. inappropriate input of a client to a given system
3. inappropriate maintenance of a client within a system
4. inappropriate extrusion from a system
5. over-identification with the client
6. chaotic programming to meet client needs

been used clinically but no attempts have been made to scientifically validate it. It is at the very least a useful tool in communicating about the types of problems faced by the various consultants.

In addition to assessing the types of dysfunction that exist in various community systems, the model calls for an assessment of the degree to which the system is in a state of disequilibrium or crisis. Our measures of crisis in the community system are very crude and based on an explanation of the behaviors described by Caplan and others in relation to crisis at the individual and family level. Thus, an attempt is made to assess the degree of tension in the system, the degree of random problem solving behavior, the degree of disorganization and the degree to which the system is perceived as useless, hopeless (etc.) by the individuals who are a part of the system. Using this data about dysfunction or crisis state, an intervention plan is developed for the community system.

Data on which the assessment process is based come from three major sources. First, there is the mental health clinic's direct treatment program. This is the starting point for all agency consultation programs. Initially, consultation contacts were made based on the needs of individual treatment cases. The number and type of cases referred to the agency by any community institution is one consideration in establishing and maintaining a consultative relationship with the community system. Individual clients provide information about community systems through descriptions of their own interactions with these systems. Additional reports and feedback from the community agencies regarding clients provide further information as to how community systems function. Approximately 80% of cases are referred by other agencies in the community, so this is a massive amount of information.

As an outgrowth of this input, a community liaison system has been established at the Child Guidance Center. Consultants are assigned liaison responsibility with various schools and community agencies (Halpern, Gant and Canale, 1978) and function as conduits of information to those systems and as reporters of information about those systems. These liaison consultants provide case and system consultation to their assigned consultees. Additionally the liaison efforts offer a second major source of data regarding community systems.

The third major data source is the Child Guidance Center's planning and evaluation program. Needs assessment data often pinpoint gaps in community programming and provide the agency with a range of perspectives on the role of various agencies in the community. Outcome assessment of consultation projects provides a direct source of input, and analysis of the results of the agency's treatment evaluation system often has expectation for consultation. As an example, the treatment evaluation program revealed (at one point) a difference in drop-out rate between school and other referrals. Further scrutiny led to the conclusion that the mechanism the school was using to make referrals was faulty. Therefore, a consultation intervention was developed to correct the referral process.

Based on the data sources provided above, an attempt is made to put together a diagnostic picture of the major child serving systems in the community. These diagnostic data then serve as the starting point for the intervention design and implementation of interventions at the community level.

Intervention Design and Implementation

In the course of its liaison, clinical and program planning-evaluation efforts, the agency collects more data than could ever be put to use with the

limited resources available. Thus, only a limited portion of the data is even closely reviewed. Decisions about areas of focus are at this point informal but based on an assessment of those target populations which represent high risk for emotional disturbance. Data for these decisions come from the agency's treatment evaluation system, clinical feedback, needs assessment information, and analysis of community demographics.

Beyond this point a more formal intervention planning system is used. Once a general target area is defined, data from those systems thought to be more clearly related to the problem are reviewed. A number of system problems are identified and the solution of which are potential intervention goals.

The next step in the process is the development of an explanatory model on which to base intervention planning. Figure 3 outlines a set of working hypotheses used by agency staff to explain various community system behavior problems. These hypotheses are based on a wide range of theory in the existing community mental health literature and the classification system represents a way of organizing that body of knowledge so that staff can communicate effectively about the issues.

At the point at which the problem has been targeted and the explanatory hypothesis developed, the data collected on agency disequilibrium are brought into play. First an assessment is made as to whether the identified problem is amenable to growth enhancement development or crisis approach to change. If the latter is the case, the degree to which crisis is likely to occur or can easily be induced in the system is assessed.

Based on this assessment, a decision is made either to plan a development intervention, a crisis intervention, or to focus effort elsewhere. If the

Fig. 3

I. Caretaker Level

A. lack of knowledge or skill

B. interference with appropriate functioning raised by consultee emotional problem or value system

II. Institutional Level

A. system interaction

B. system communication problems

C. system power structure problem

D. system values in conflict with mental health values

E. lack of resources within system

III. Community Level

A. inter-agency communication problem

B. inter-agency power structure problem

C. lack of community resources

decision is made to continue with the project, planning at this point becomes rather concrete and specific and strategies are developed by which to carry out the project. Growth enhancement is typically in-service training of one sort or another. In many instances the Child Guidance consultant, in cooperation with the consultee agency, develops workshops or ongoing in-service sessions targeted at specific areas of deficit, such as lack of crisis intervention skills among temporary youth workers at a run-away center or lack of child development knowledge among teacher's aides in a day care program. At other times, the consultant may use a case consultation model to help the consultee to develop new skills. In many cases, growth enhancement simply consists of providing support while the consultee experiences new problems and comes to problem solutions on his own. This is often important in school settings where consultant support can allow a teacher to experiment with creative solutions to a problem which would not otherwise be sanctioned. Typically, growth enhancement projects are rather straight forward with needs being easily identified and program solutions being rather obvious.

Crisis-centered interventions present a much more complicated picture. Typically, those changes needing a crisis approach are the more deviant community system behaviors. For example, a school system that repeatedly forces problem students to drop out, or a welfare system which through its bureaucracy continually degrades its clients. The hallmark of system behavior needing crisis center change activities is its persistence in the face of evidence that such behavior is dysfunctional. Developing a crisis-centered intervention requires either waiting for a crisis to occur in the identified community system or actually precipitating one. In practice, consultants often have a number of potential crisis centered projects in mind with a system they are working with and implement one of those when a crisis occurs. Crisis-

centered interventions usually have less substance than growth enhancement interventions. In terms of consultant behavior, they often take the form of a lot of program development and administration consultation although sometimes case consultation, or even staff development projects become part of the methodology of a crisis-centered intervention. In most cases crisis-centered approaches take advantage of naturally occurring crises in community systems.

Often systems crises are related to the departure of key personnel in a community system. For several years this agency was preferred to the activities of the Youth Service System run-away shelter. Through liaison activities, we were able to get a good picture of the problems workers had in getting support from the youth service agency. At one point, the Director of the run-away shelter was fired, throwing the whole system into chaos. The Child Guidance consultant was able to work with the overall Youth Service System administration and allow us more access to staff for in-service training and provision of ongoing support. This put the consultant in a very advantageous position in working with the Director hired to fill the vacant position. By having a plan and some knowledge of the system in advance, the Child Guidance Center was able to take advantage of the crisis and help the Youth Service System become more open to outside support.

A second frequent source of agency crisis is the client with unsolvable problems who cannot be excluded from the system. The agency's work with the Welfare Department presents a number of examples of this type of crisis. A target problem for our welfare consultant was a communication problem between the welfare department and the public health nurses. By utilizing a case which created a crisis for both systems and then planning with them together around that specific case, the consultant was able to begin a change which

led to a system of community staffings in the welfare department and a much better relationship between the public health nurses and the protective service workers.

In one instance, a fiscal crisis at the regional state mental hospital allowed us to make major changes in the day treatment program by providing additional resources for that program. For sometime, we recognized the limited degree to which the hospital program maintained linkage with the community. The hospital was reluctant to modify that stance until a budget cut forced them to eliminate social work and psychological services to the day treatment program. Child Guidance Center provided these resources and in the process was able to develop a program with a much stronger community base.

At times Child Guidance can precipitate crisis in community agencies by manipulation of its own agency policies. An example of this has occurred in our relationship with the juvenile court. A system problem pinpointed within the court had to do with the agency's lack of administrative control over individual probation officers. One facet of this lack of control was the inability of the court to structure a uniform procedure for referring cases to the Center. A crisis was created by changing our policy so that all referrals had to go through the Center's consultant and by actually refusing cases that came to us in any other manner. The pressure of their clients calling back the probation officers without appointments, forced the court to allow our consultant to intervene by helping them develop a more centralized referral process. In the course of this effort he was able to discuss some systems issues with the juvenile court judge and work with him to implement a plan of change.

Control of the referral process and the provision or non-provision of consultation services are major mechanisms by which the Center can precipitate

crises in other community systems. These techniques, however, have not been used with great frequency since they frequently generate a great deal of hostility. Used with care and a lot of fine planning, they can be extremely effective in creating change. The notion of systematically taking advantage of such crises and even precipitating crisis to change systems, is probably the most unique aspect of the agency's community intervention program. The concepts related to this approach and the techniques used are still very much in a formative stage. It is hoped that, in the future, a presentation of these approaches in more detailed form will be available.

Evaluation

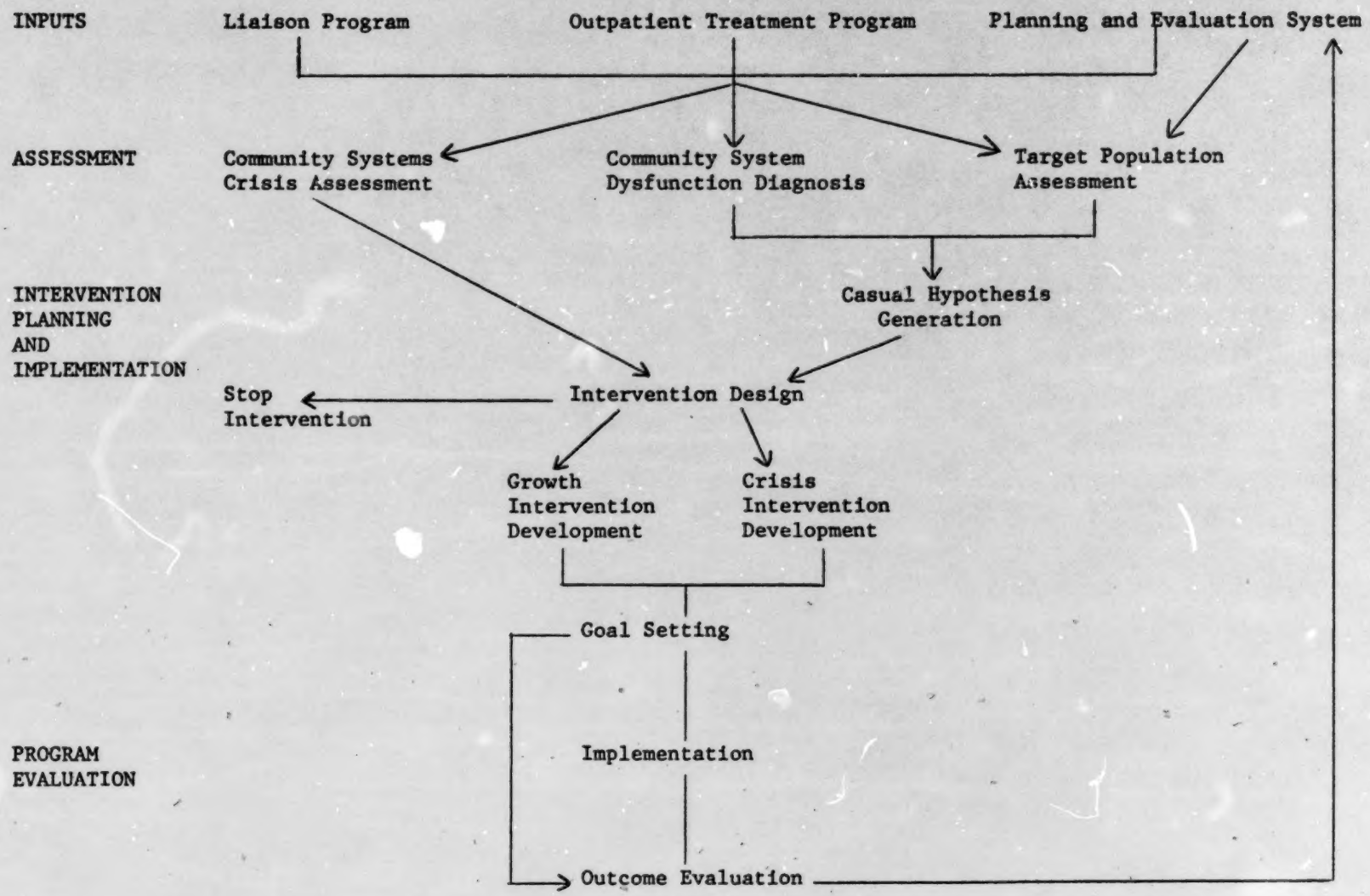
As mentioned above, the agency utilizes program evaluation data in community system assessment. Because of this, the agency has developed a stronger commitment to evaluation and has now reached the stage where all consultation interventions are evaluated.

The first step in the evaluation process takes place during the program development stage. During planning, short term measurable "evaluation goals" are established for each program as well as long term outcome goals. Assessment of the degree of goal attainment represents the minimally acceptable program evaluation steps. The major function of this goal assessment is, of course, to evaluate the intervention effectiveness. It is clear, however, that especially in the case of project failures, a good deal may be learned about consultee agencies when the reasons for failure to attain goals are carefully analyzed.

Summary and Conclusions

Fig. 4 summarizes the process by which the system crisis model has been applied to mental health consultation. Input provided by the agency's

Fig. 4 SUMMARY OF USE OF SYSTEMS CRISIS MODEL IN MENTAL HEALTH CONSULTATION



community liaison program, the outpatient treatment program, and the planning and evaluation program for the agency is utilized to generate a diagnostic picture of a wide range of community systems. Potential target populations are prioritized based on data from the planning and evaluation system, and the problems in a number of systems related to those target populations are analyzed in order to generate a causal description for identified problems. These data and data from a crisis assessment are utilized to develop a growth-oriented program, a crisis-based change program or to terminate program planning. Specific plans for programs are then developed. Goals are set, the program is implemented and evaluated, and the data are fed back to the systems.

The development of this approach has been evolutionary, moving from a global desire for community involvement to an attempt to systematically describe what was going on in the community to an attempt to systematically change what is going on in the community. It has been most effective in helping the agency set priorities, so as to deal with the problem of limited resources, in providing a language and a set of concepts to make communication between agency consultants clearer and in providing a rationale and a conceptual base for the development of program designs.

In the past year, the agency has begun to focus more of its efforts on developing preventative programming and the crisis systems model has been of great aid in targeting high risk populations and systems within which to develop preventative programming. It is felt that with more experience the agency will be able to more fully describe what takes place during the process and to develop a systematic assessment of the effectiveness of various projects and techniques.

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